

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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**D FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
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09953

**CERTIFICATE OF DEATH**

09945

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 days-19 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital			d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Orval	Middle Carlton	Last Bittinger	4. DATE OF DEATH July 4, 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1884	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Buliding		11. BIRTHPLACE (County & State, or foreign country) Bittinger, G. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Amos Bittinger			14. MOTHER'S MAIDEN NAME Elizabeth (Daughter)			Brenneman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 212-21-0912A		17. INFORMANT Mrs. Melvin Sisler, Mt. Lake Park, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Arteriosclerosis, generalized						INTERVAL BETWEEN ONSET AND DEATH 18 hours Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 26th, 1966 to July 4, 1966, that (I) (we) last saw the deceased alive on July 4, 1966, and that death occurred at 6:05 AM from causes and on the date stated above							
22a. SIGNATURE Dr. James H. Feaster, Jr.				22b. DATE SIGNED 7-4-66			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 7/5/66		23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cem.		23d. LOCATION (City or Town) Near Oakland, Md.	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5, may be retained for your files.

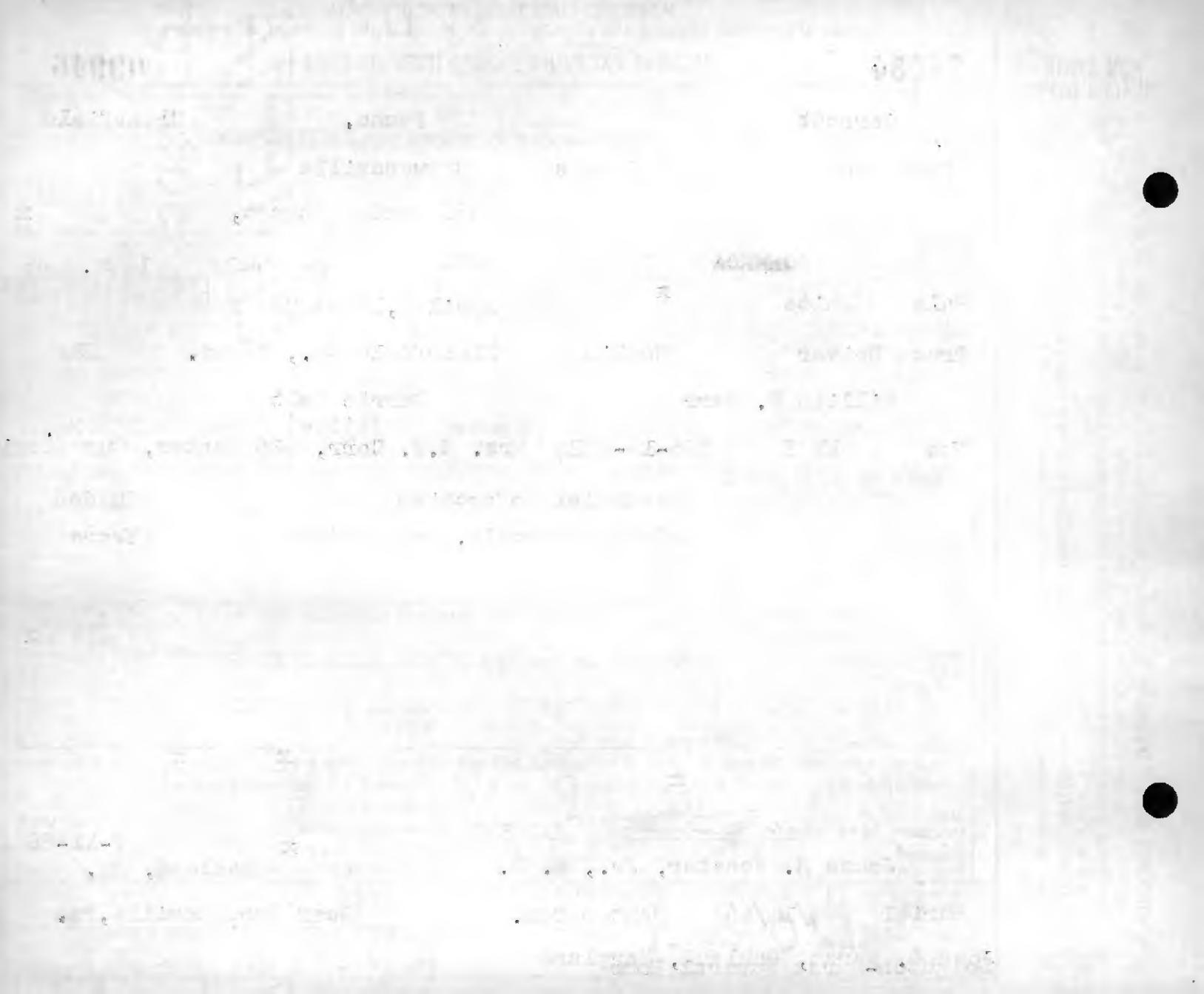
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09946

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Clearfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sang Run</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SCENECA</b> First <b>THOMAS</b> Middle <b>CARR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10th.</b> 19 <b>66</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 8, 1888</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearfield Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William R. Carr</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Holt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>06-16-4924</b>	
17. INFORMANT <b>(Widow)</b>		Address <b>Mrs. S.T. Carr, 626 Center, Curwensvile, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerosis, generalized</b>		DUE TO (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>(County)</b> <b>(State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>7-11-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Type) <b>Burial</b>		23b. DATE THEREOF <b>7/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Center Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Curwensville, Pa.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>John J. Durst</b> <b>Leighton Durst Funeral Home, Oakland, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. Feaster</i>	



FOR STATE  
HEALTH DEPT.

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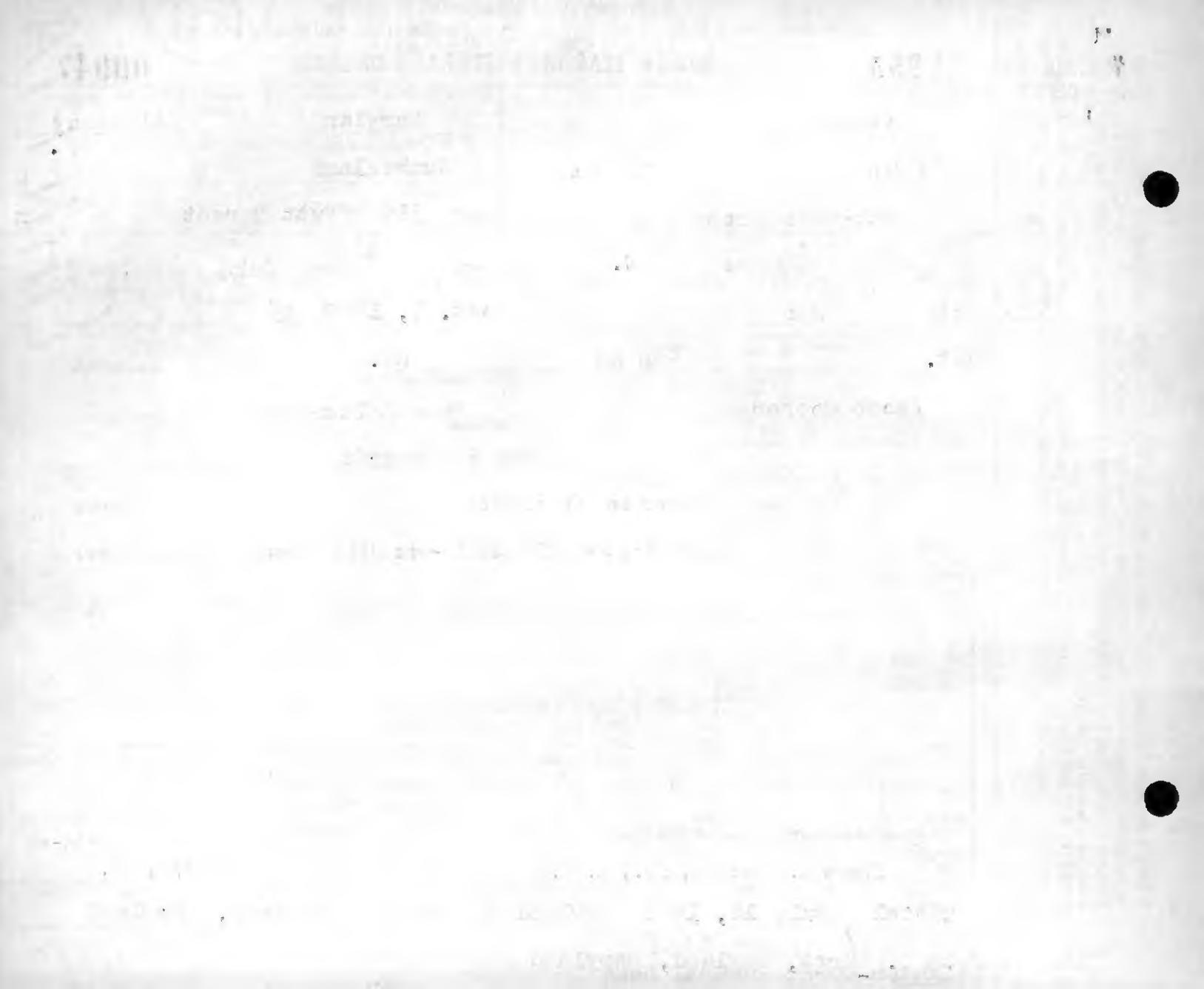
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 12 Film G379 7/26/66 mb

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09947

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cuppett-Weeks Nursing Home			d. STREET ADDRESS Rear 319 Offutt Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles C. Cooper		First Middle Last		4. DATE OF DEATH July 14th. 1966		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1880	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.			10b. KIND OF BUSINESS OR INDUSTRY B&O RR			11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? Unknown
13. FATHER'S NAME Jacob Cooper			14. MOTHER'S MAIDEN NAME Emma Boltwright			Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT B&O RR Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u> DUE TO Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 7-14-66		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 18, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery		23d. LOCATION (City or Town) (County) (State) Oakland, Maryland		
24. FUNERAL DIRECTOR John O. Dirst John O. Dirst Oakland, Maryland Leighton-Dirst Funeral Home		ADDRESS			25a. REC'D BY REGISTRAR JUL 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

09956

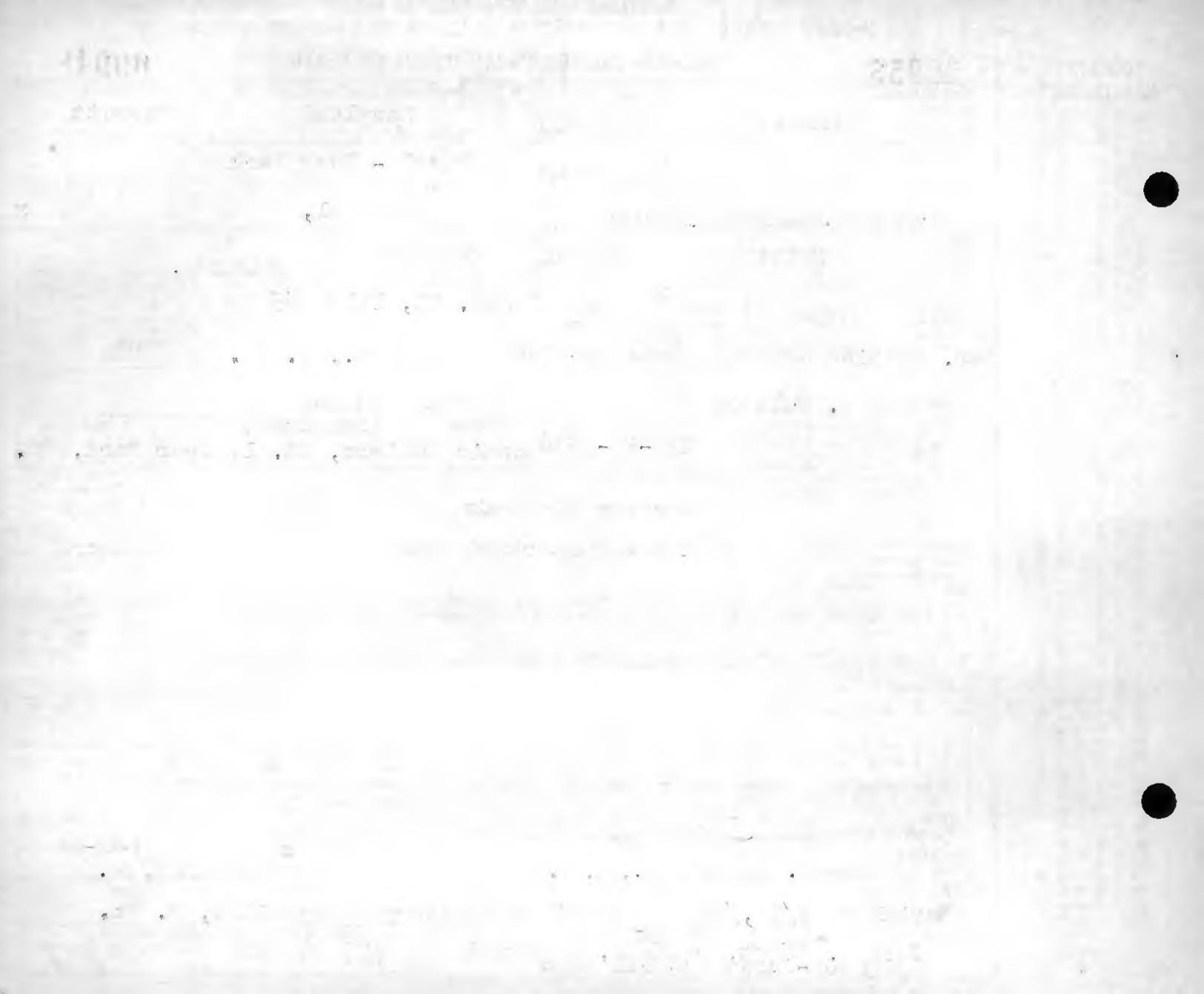
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09948

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1		2		3	
1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 15 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Deer Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital		d. STREET ADDRESS Route #1,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN		Middle GORMAN		4. DATE OF DEATH Month July 27th, Year 1966	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ser. Station Owner		9. DATE OF BIRTH INDUSTRY Nov. 22, 1910		10. AGE (In years at birthday) 95 yrs.	
11. BIRTHPLACE (State or foreign country) Hardy Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arthur G. Cullers		14. MOTHER'S MAIDEN NAME Sena Mathias			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-26-3536		17. INFORMANT (Daughter) Address Bonnie Cullers, Rt. 1, Deer Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary arteriosclerosis				Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 7-27-66	
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/66		23c. NAME OF CEMETERY OR CREMATORIAL Maysville Cemetery	
23d. LOCATION (City or Town) (County) (State)				23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR John O. Durst		24b. ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE AUG 1 1966	
Leighton-Durst Funeral Home				25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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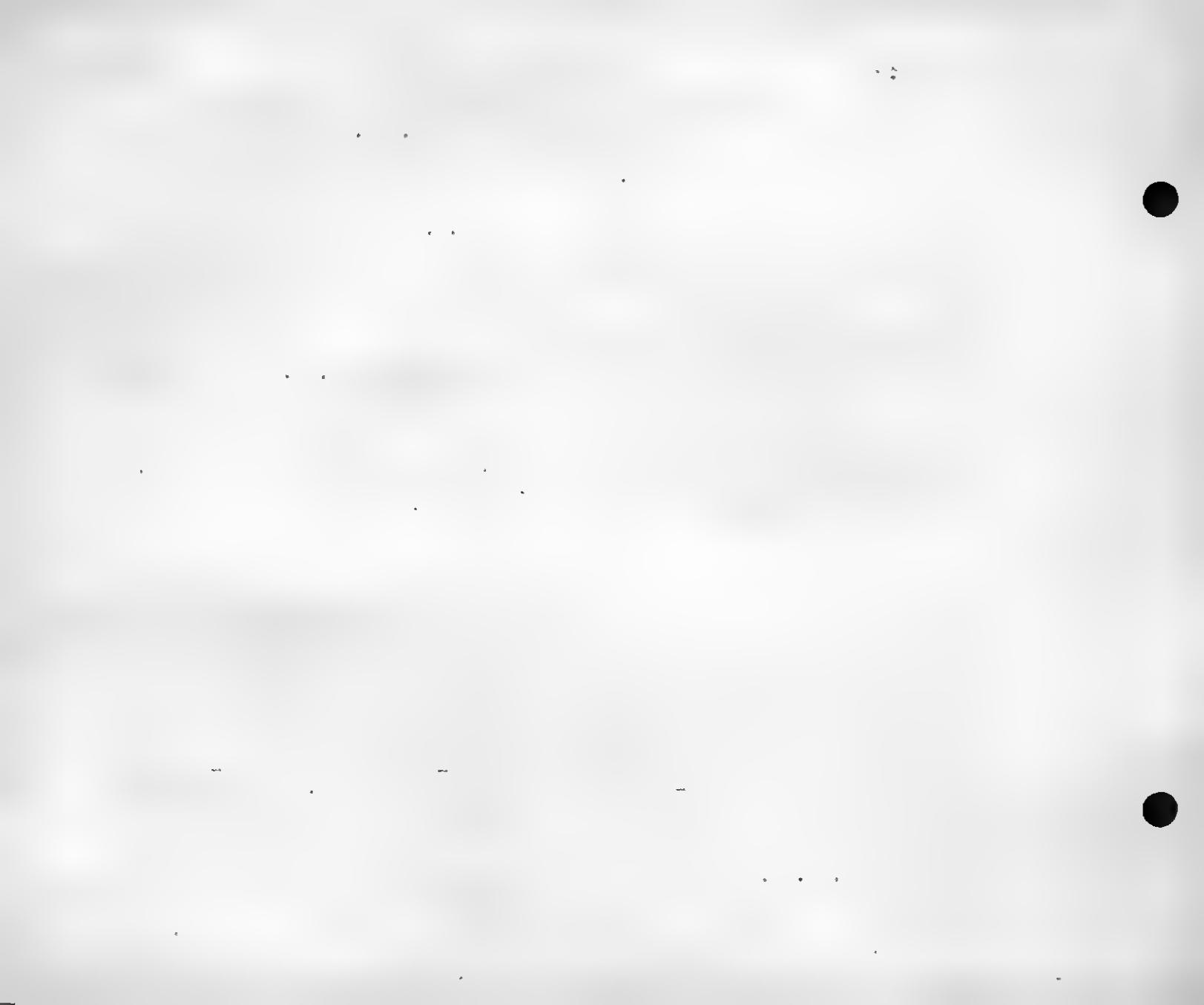
CERTIFICATE OF DEATH												09949			
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY		Garrett		MARYLAND		a. STATE		West Virginia		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Oakland		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Piedmont		Mineral					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS									
Garrett County Memorial Hospital						98 W. Hampshire St.									
												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Lewis		Middle		Last Domenick, Sr.		4. DATE OF DEATH		Month July 16.		Day 19	Year 66		
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days Hours Min.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		October 17, 1892									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Laboratory Technician				Paper Mill				Italy				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Carmen				Domenick				Philomomia				Ragno			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
YES U. S. I.				217-05-6417				Lewis Domenick, Jr. Oakland, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Arteriosclerosis</u>												<u>1966</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
July 16, 1966															
21. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1966</u> , to <u>July 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 16, 1966</u> , and that death occurred at <u>11:15 A.M.</u> from causes and on the date stated above.															
22a. SIGNATURE <u>A. S. Mance</u>												22b. DATE SIGNED <u>17 July 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. S. Mance</u>				22d. ADDRESS <u>Oakland, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/17, 1966</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Peters</u>				23d. LOCATION (City or Town) <u>Westernport</u>				(County) <u>Md.</u>		(State)	
24. FUNERAL DIRECTOR <u>E. Boal</u>		ADDRESS <u>Westernport, Md.</u>		25a. RECD BY REGISTRAR <u>JUL 20 1966</u>				25b. REGISTRAR'S SIGNATURE <u>John Judge</u>							
VR A15 (4) 20 M 1/66															



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH												19950			
1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>W. Va.</b>						b. COUNTY <b>Tucker</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>15 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bayard</b>			d. STREET ADDRESS <b>P.O. Box 61</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>						e. DATE OF DEATH <b>July 23, 1966</b>						f. MONTH <b>July</b>		g. DAY <b>23</b>	
3. NAME OF DECEASED (Type or print)		First <b>Albert</b>		Middle <b>William</b>		Last <b>Dunithan</b>		4. DATE OF DEATH <b>July 23, 1966</b>		Month <b>July</b>		Day <b>23</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/28/1882</b>		9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 24 HRS Months <b>0</b>			
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maysville, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>America</b>			
13. FATHER'S NAME <b>George Dunithan</b>						14. MOTHER'S MAIDEN NAME <b>Matilda Shirteager</b>						Address <b>Bayard, W. Va.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>						16. SOCIAL SECURITY NO. <b>218-09-5404</b>						17. INFORMANT <b>Mrs. Helen Roy</b>			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Lymphangitis.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>6mos.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Fibrosarcoma. bsd</b>															
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) <b>Bayard</b>		(County) <b>W. Va.</b>		(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7-8-1966</b> to <b>7-23, 1966</b> , that (I) (we) last saw the deceased alive on <b>7-23, 1966</b> , and that death occurred <b>06:37 A.M.</b> from causes and on the date stated above.															
22a. SIGNATURE 						22b. DATE SIGNED <b>7-23-1966</b>									
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>						22d. ADDRESS <b>Oakland, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Surfay</b>			23b. DATE THEREOF <b>7/25/66</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Bayard Cemetery</b>			23d. LOCATION (City or Town) <b>Bayard</b>			(County) <b>W. Va.</b>		(State)	
24. FUNERAL DIRECTOR <b>Gerald J. Minnich</b>						ADDRESS <b>Oakland, Maryland</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
20 A15 (4) 20 M 1/66												DATE JUL 27 1966			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CS953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09951

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville	
f. STREET ADDRESS Rt. 1, Box 33		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy May Frazee		4. DATE OF DEATH July 31st, 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED Widowed		8. NEVER MARRIED Divorced	
9. B. DATE OF BIRTH 4/29/1890		10. AGE (In years 76 yrs lost birthday)	
11. BIRTHPLACE (State or foreign country) Friendsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Ella Meyers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 135-18-0545A	
17. INFORMANT Mr. Charles Frazee, Friendsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Artiosclerotic cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured left hip.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) Fell out of bed 7-18-66 Garr. Co. Mem. Hosp. & fractured hip	
20c. TIME OF INJURY Month, Day, Year Hour: min 6:30 AM 7-18-66 19		20d. PLACE OF INJURY (Name, firm, factory, street, office bldg, etc) Oakland Garr. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 7-31-66	
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/3/66	
23c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose Cem.		23d. LOCATION (City or Town) (County) (State) Friendsville, Garrett, Md.	
24. FUNERAL DIRECTOR Ruth E. Newman		25a. ADDRESS Grantsville, Md.	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

39960

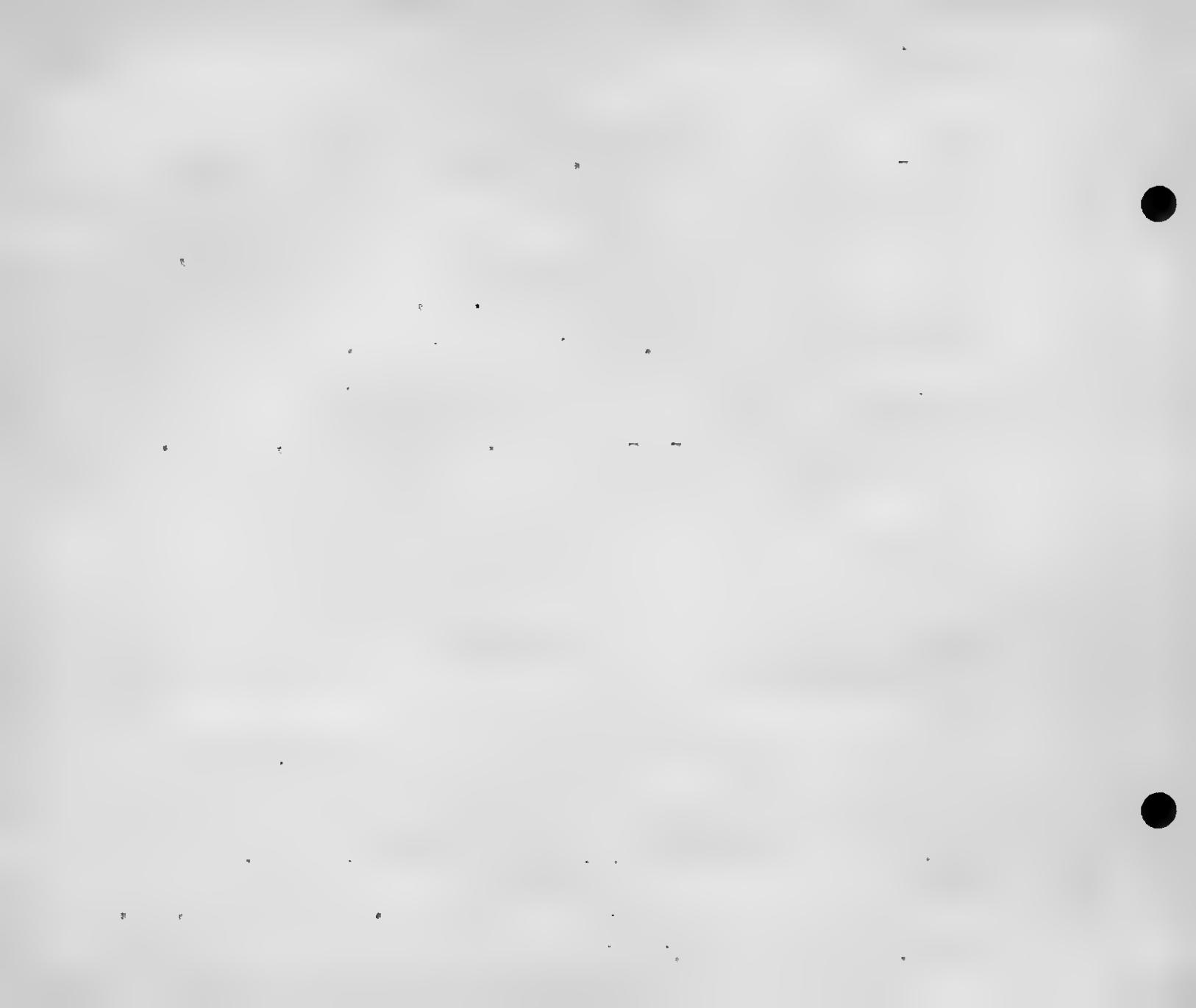
## CERTIFICATE OF DEATH

09952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporal limits, write RURAL and give nearest town) Rural - Oakland		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Star Route		e. CITY OR TOWN (If outside corporal limits, write RURAL and give nearest town) Rural - Oakland	
3. NAME OF DECEASED (Type or print) SIDNEY		4. DATE OF DEATH HARVEY July 3, 1966	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1880	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Deys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	
11. BIRTHPLACE (County & State, or foreign country) Deer Park, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josephus Harvey		14. MOTHER'S MAIDEN NAME Mary Peck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-38-1304	
17. INFORMANT (Widow)		Address Mrs. Sidney Harvey, Star Rt., Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 yrs	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		DUE TO Anute Myocardial infarction Cardiac Vascular and Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 2b.)	
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to July 3, 1966, that (I) (we) last saw the deceased alive on June 30, 1966, and that death occurred at M, from the causes and on the date stated above.			
22e. PHYSICIAN'S NAME Ralph Calandrella, M.D.		22b. DATE SIGNED July 4-66	
22e. ADDRESS Kitzmiller, Md. 21558		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23e. BURIAL, CREMATION, DATE THEREOF REMOVED July 6, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Rodeheaver Family Cem. Near Oakland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Durst, Oakland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 8 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

C9961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

119953

1 PLACE OF DEATH a COUNTY Garrett MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penns. b. COUNTY Allegheny	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Oakland Minutes		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS 1229 Washington Road,	
		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Patrick Mark Higgins		First Middle Last	4 DATE OF DEATH Month July Day 24th. Year 1966
5 SEX Male White		6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY College	
11 BIRTHPLACE (State or foreign country) Pittsburgh, Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mark B. Higgins		14. MOTHER'S MAIDEN NAME Jean Genkinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 188-36-1339	
17. INFORMANT (Father)		Address Mark B. Higgins, Pittsburgh, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost		DUE TO Crushed chest	
DUE TO (c)		Sudden	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) One car a uto accident Rt. 219 5mi. N. of Oakland, Md.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 1-15 AM 7-24-66 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) (Rural) Oakland Garr. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oakland, Md.	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		22. DATE SIGNED 7-24-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL Queen of Heaven		23d. LOCATION (City or Town) (County) (State) Peters Twp. Washington Co. Penna.	
24. FUNERAL DIRECTOR John O. Durst		ADDRESS John O. Durst, Oakland, Maryland Leighton-Durst Funeral Home	
		25a. REC'D BY REGISTRAR DATE JUL 26 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and item 7 with the State Department of Health if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

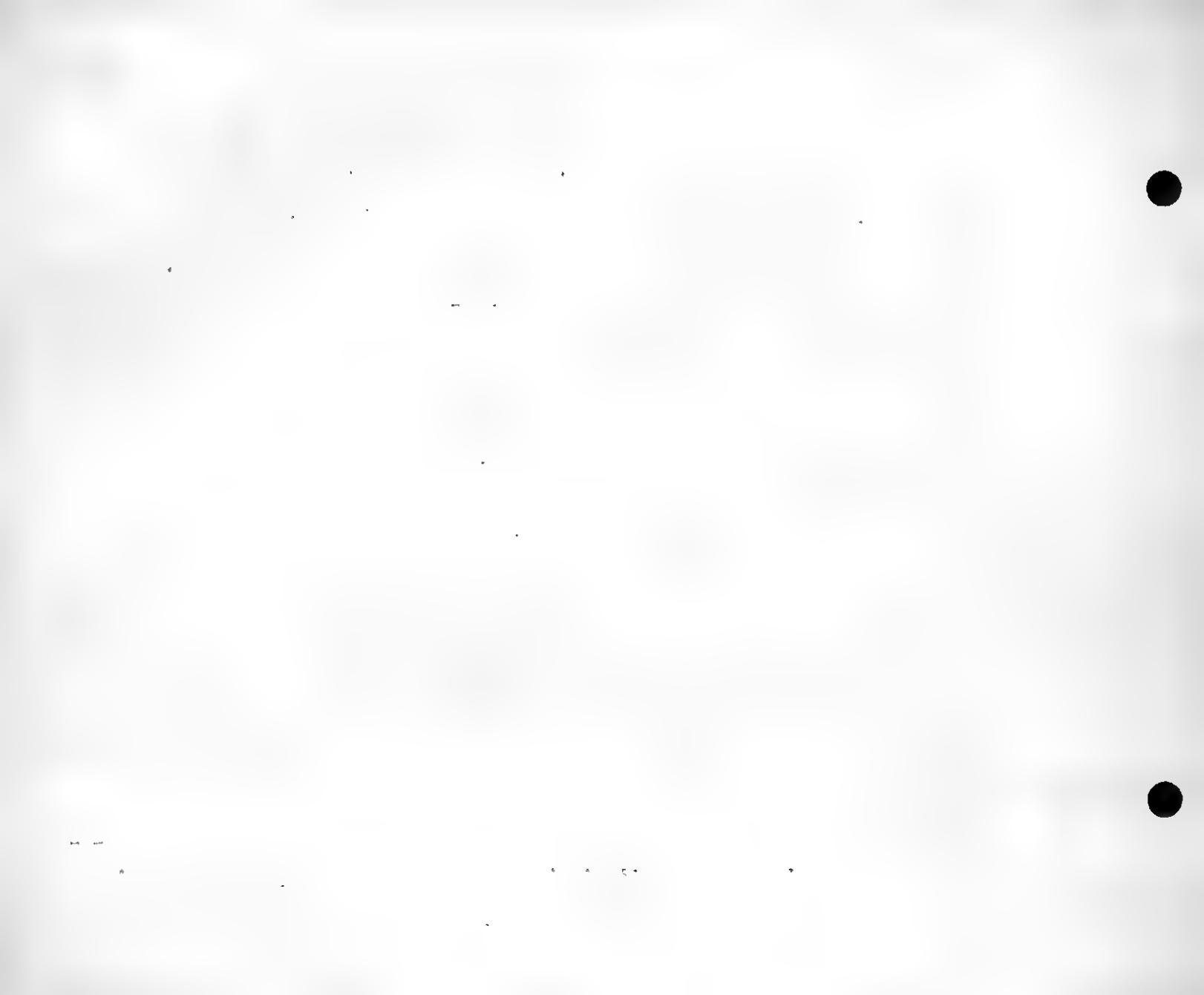
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09962

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09954

1 PLACE OF DEATH a. COUNTY Garrett MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 18½ hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Memorial Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		
3 NAME OF DECEASED (Type or print) First John Middle Joseph Last Martin			d. STREET ADDRESS 202 I Street		
4 DATE OF DEATH July 7th, 1966			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-16-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR IND.STRY Railroad		11 BIRTHPLACE (State or foreign country) Red House, Md.	
13. FATHER'S NAME John L. Martin			14. MOTHER'S MAIDEN NAME Mary Rolf		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no		16. SOCIAL SECURITY NO. 215-20-5424		17. INFORMANT Mrs. Ida Sutton Oakland, Maryland Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Hours Years		
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James H. Feaster, Jr., M. D.</u> M.D.					
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
24. FUNERAL DIRECTOR Gerald D. Minnich		23d. LOCATION (City or Town) Oakland, Md.		(County) (State)	
25a. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUL 14 1966 Charles Judge					
VR A15ME (5) 6M 1/66					



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the words "Delayed" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09963

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09955

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 31hrs. 55min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Gorman, W. Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett Co. Mem. Hosp.			d. STREET ADDRESS		e. S. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First ROY	Middle BENJAMIN	Last MILLER	4. DATE OF DEATH July 28th, 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 18, 1892	9. AGE (in years at birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal		11. BIRTHPLACE (State or foreign country) Shenandoah Co., Va.	
13. FATHER'S NAME Jeremiah Miller			14. MOTHER'S MAIDEN NAME Nancy Minnick		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 436-14-6858		17. INFORMANT Mrs. Wayne Liller, Gorman, W. Va.	Address (Dau.)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S (NAME & Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Oakland, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (S) P.D. Burial	23b. DATE THEREOF 7/31/66	23c. NAME OF CEMETERY OR CREMATORIAL Pope Cemetery	23d. LOCATION (City or Town) Gorman, Garr. Co., Md.	(County)	(State)
24. FUNERAL DIRECTOR John O. Durst Leighton-Durst Funeral	ADDRESS Home, Oakland, Md.	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE	22. DATE SIGNED 7-28-66	
VR A15ME (5) 6M 1/66		DATE AUG 1 1966			



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

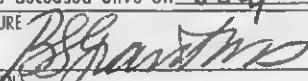
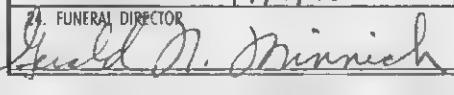
## CERTIFICATE OF DEATH

09956

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09964

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN b 1 day-8 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles William Niner		4. DATE OF DEATH July 6, 1966	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
10b. US OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer		10b. KIND OF BUSINESS OR INDUSTRY Timber	
13. FATHER'S NAME Charles		11. BIRTHPLACE (County & State, or foreign country) Echard, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 219-14-5594		17. INFORMANT Mrs. Cora Niner Rt. 2 Deer Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1965 to July 1966, that (I) (we) last saw the deceased alive on July 6, 1966, and that death occurred at 6:10 AM from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 6 July 66	
22c. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/66	23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery
24. FUNERAL DIRECTOR 		23d. LOCATION (City or Town) Deer Park (County) Maryland (State)	
ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE JUL 11 1966	25b. REGISTRAR'S SIGNATURE 



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

09965

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09957

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Garr tt</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>15½ hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (First Middle) <b>Cora Ellen Opel</b>		4. DATE OF DEATH <b>July 27th 1966</b>	Month Day Year
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/18/88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Keyser's Ridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Opel</b>		14. MOTHER'S MAIDEN NAME <b>Catharine Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT <b>Mrs. Oscar Harman, Accident, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured right hip.</b>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Apparently fell at home between 22nd. and 25th. of July</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>July 19 p.m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>7-27-66</b>	
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/30/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Johns Ch. Cem.</b>
24. FUNERAL DIRECTOR <b>Rich E. Neumann</b>		ADDRESS <b>Grantsville, Md.</b>	25a. RECEIVED BY REGISTRAR <b>Accident, Garrett, Md.</b>
		DATE <b>AUG 3 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09966

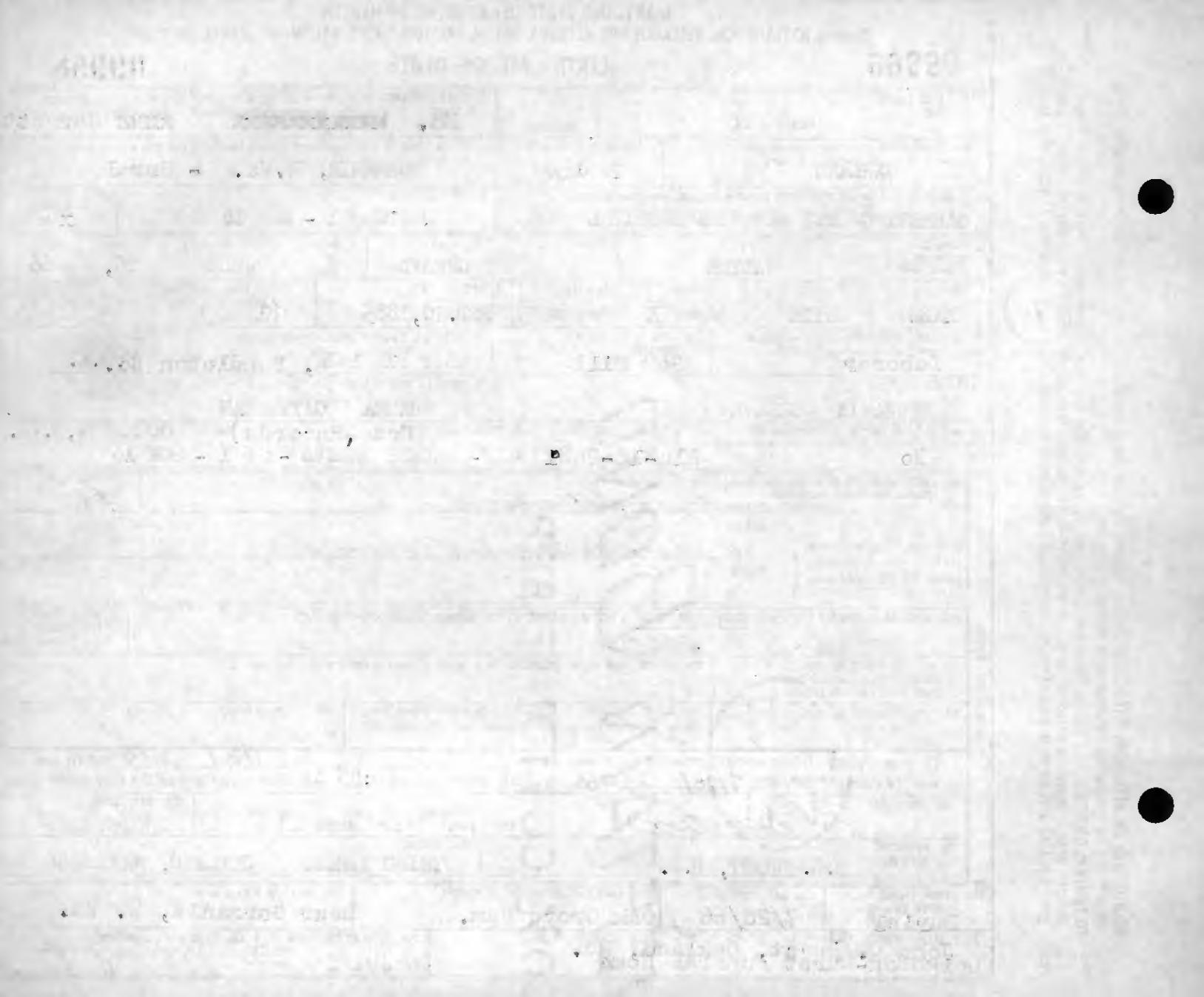
## CERTIFICATE OF DEATH

09958

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> COUNTY <b>Garrett</b> <b>John B. Grant</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WALTER</b>		First <b>SHREVE</b>	Middle <b>SHREVE</b>
4. DATE OF DEATH <b>FEB. 20, 1885</b>		Month <b>JULY</b>	Day <b>26,</b> 19 Year <b>66</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <b>FEB. 20, 1885</b>		9. AGE (In years last birthday) <b>81</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA, Pendleton Co. S.A.</b>
13. FATHER'S NAME <b>BENJAMIN SHREVE</b>		14. MOTHER'S MAIDEN NAME <b>HANNA CATERMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-2681</b>	17. INFORMANT (Hosp. Records) Address <b>GORMANIA, W.VA.</b> SELF - WALTER SHREVE - R # 1 - BOX 16
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO 4201		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic C.V. disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <b>7/26/1966</b> , and that death occurred <b>10:45 A.M.</b> from causes and on the date stated above.		22a. SIGNATURE <i>B. J. Grant</i>	
22c. PHYSICIAN'S NAME (Type) <b>B. J. GRANT, M.D.</b>		22b. DATE SIGNED <b>26 July 66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/28/66</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Oak Grove Cem.</b>
24. FUNERAL DIRECTOR <b>John B. Durst</b> ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 28 1966</b>	
Leighton Durst Funeral Home		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>											
09967						09959					
<p>1. PLACE OF DEATH            a. COUNTY <b>Garrett</b> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b></p> <p>c. LENGTH OF STAY IN lb <b>1 Hr. 22 Min.</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegheny</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b></p> <p>d. STREET ADDRESS <b>43 Woodside Road</b></p>					
<p>3. NAME OF DECEASED (Type or print) <b>Michael Joseph Weisenmiller</b></p> <p>First <b>Michael</b> Middle <b>Joseph</b> Surname <b>Weisenmiller</b></p> <p>5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>July 28, 1966</b> 9. AGE (In years lost birthday) yrs. <b>19</b></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>						<p>4. DATE OF DEATH <b>July 28, 1966</b></p> <p>Month <b>July</b> Doy <b>28</b> Year <b>1966</b></p> <p>IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>            Months <b>1</b> Doy <b>22</b> Hours <b>1</b> Min. <b>22</b></p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Infant</b></p>						<p>10b. KIND OF BUSINESS OR INDUSTRY</p>					
<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Oakland, Garrett</b></p>						<p>12. CITIZEN OF WHAT COUNTRY? <b>America</b></p>					
<p>13. FATHER'S NAME <b>John Conrad Weisenmiller</b></p>						<p>14. MOTHER'S MAIDEN NAME <b>Barbara Ellen Lutz</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p>						<p>16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>John Conrad Weisenmiller</b> Address</p>					
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Prematurity (5 1/2 mos. gestation, Wt. 11b 9oz.)</b></p> <p>776X</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) _____</p> <p>(c) _____</p>						<p>INTERVAL BETWEEN ONSET AND DEATH <b>1hr. 22min.</b></p>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)</p>						<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year            Hour o.m. <b>19</b></p>						<p>20d. INJURY OCCURRED            While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) <b>Oakland</b> (County) <b>Maryland</b> (State) <b>Md.</b></p>					
<p>21. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1966</b> to <b>July 28, 1966</b>, that (I) (we) last saw the deceased alive on <b>July 28, 1966</b>, and that death occurred at <b>6:00AM</b> from causes and on the date stated above.</p>											
<p>22a. SIGNATURE <i>John O. Durst</i></p>						<p>22b. DATE SIGNED <b>7-28-66</b></p>					
<p>22c. PHYSICIAN'S NAME (Type) <b>Dr. J. H. Feaster, Jr.</b></p>						<p>22d. ADDRESS <b>Oakland, Maryland</b></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>						<p>23b. DATE THEREOF <b>7/29/66</b> 23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Peter's Cath.</b></p>					
<p>24. FUNERAL DIRECTOR <b>John O. Durst</b></p>						<p>23d. LOCATION (City or Town) <b>Oakland</b> (County) <b>Maryland</b> (State) <b>Md.</b></p>					
<p>Leighton-Durst Funeral Home, Oakland, Md.</p>						<p>25a. REC'D. BY REGISTRAR <b>AUG 1 1966</b> 25b. REGISTRAR'S SIGNATURE <i>James Judge</i></p>					

